ASSIGNED CODE

or affix label here

## Consumer Information

If question is irrelevant or information not known, write

Not Applicable or NA

|  |  |  |
| --- | --- | --- |
| **Consumer Details** |  |  |
|  |  |  |
| Family Name: |  | Sex (circle one) Male Female |
| Given Names: |  | Title (circle one) Mr Mrs Ms Other  |
| Date of Birth *dd/mm/yy / /* |  |  |
| Preferred Name/s: |  |  |
|  |  |  |
| **Contact Details** |  |  |
| Contact Address (for correspondence, etc) |  | Contact Phone Number/s (tick preferred number)Can leave message? Y or N |
|  (number) (street) |  | Home: |
|  (suburb/locality) (postcode) |  | Work: |
|  |  | Mobile |
|  |  | Fax: |
| **Who the Agency Can Contact if Necessary**  |  | Email: |
|  |  |  |
| Person 1 Name: |  | Person 2 Name: |
| Contact Details |  | Contact Details |
|  (number) (street) |  |  (number) (street) |
|  (suburb/locality) (postcode) |  |  (suburb/locality) (postcode) |
| Phone: |  | Phone: |
| Relationship to Client: |  | Relationship to Client: |
|  |  |  |
| **General Practitioner** (if no GP, write NA) |  | **This Page Completed By:** (tick one) |
| Name: |  | 🞏 The consumer or someone who represents the Consumer  (carer, parent or guardian) |
| Address: |  | 🞏 The agency (face-to-face with consumer) |
|  |  | 🞏 The agency (other, incl. telephone contact with consumer) |
| Phone: |  |  |
| Fax: |  |  |
| Email: |  | Consumer privacy information brochure provided? 🞏 Yes 🞏 No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Office Use Only** |  |  |  |  |
| Name: | Designation/Agency:  |
|  |  |  |  |  |
| Sign: | Date: | Contact Number:  |
| If information becomes superseded, indicate below and record updated information on new form |
|  |  |  |
| The information on this form has been superseded |
| Date: | Name: | Sign: |
|  |  |  |

ASSIGNED CODE

or affix label here

## Consumer Information

If question is irrelevant or information not known, write

Not Applicable or NA

|  |  |  |
| --- | --- | --- |
| **Service Requested** |  | **Main Language Spoken at Home** 🞏 |
| - Sustainable Farm Families™ program |  | Record: (1) English |
|  |  | (2) Other |
|  |  | If other, specify: |
|  |  |  |
|  |  | **Interpreter Required** 🞏 |
| **Notes:** (including alerts and comments on risks, urgency and |  | Record (1) Interpreter not needed. |
|  access issues) |  | (2) Interpreter needed. |
|  |  |  |
|  |  | **Preferred Language** |
|  |  | (if not spoken English), include sign Language, and any required |
| **Source of Referral**  🞏 |  | communication devices or special interpreter needs: |
| Record (1) Self |  |  |
| (2) Family, significant other, friend |  |  |
| (3) GP/medical practitioner (community-based) |  |  |
| (4) Specialist aged or disability assess team/service  |  |  |
| (5) Comprehensive HACC assessment authority |  | **Government Pensioner/** 🞏 |
| (6) Community nursing services. (7) Hospital (public) |  | **Benefit Status** |
| (8) Psychiatric/Mental health service or facility |  | Record: (1) Aged Pension. |
| (9) Extended care/rehabilitation facility |  | (2) Veterans’ Affairs Pension. |
| (10) Palliative care facility/hospice |  | (3) Disability Support Pension. |
| (11) Government residential aged care facility |  | (4) Carer Payment (pension). |
| (12) Aboriginal health service. (13) Carelink centre |  | (5) Unemployment-related benefits. |
| (14) Other community-based gvt medical/health service  |  | (6) Other govt. pension or benefit. |
| (15) Other government medical/health service |  | (7) No govt. pension or benefit. |
| (16) Other government community-based services agency |  |  |
| (17) Hospital (private) |  | Card Number |
| (18) Non-government residential aged care facility |  |  |
| (19) Other non-government medical/health services |  |  |
| (20) Other non-government community-based service |  | **DVA Card Status** 🞏 |
| (21) Law enforcement agency. (22) Other |  | Record: (1) No DVA Card. |
| **Source of Referral Contact Details:** |  | (2) Yes Gold Card. |
|  |  | (3) Yes White Card. |
|  |  | (4) Yes Other DVA Card. |
|  |  |  |
| **Country of Birth** 🞏 |  | DVA Card Number: |
| Record: (1) Australia. (2) Other. |  |  |
|  If other, specify: |  | **Insurance Status** |
|  |  | Insurer Name and Card Number: |
| **Indigenous Status** 🞏 |  |  |
| Record: (1) Aboriginal but not Torres Strait Islander origin. |  | Medicare Number: |
| (2) Torres Strait Islander but not Aboriginal origin. |  |  |
| (3) Both Aboriginal and Torres Strait Islander origin. |  | Health Care Card Number: |
| (4) Neither Aboriginal nor Torres Strait Islander origin. |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Office Use Only** |  |  |  |  |
| Name: | Designation/Agency:  |
|  |  |  |  |  |
| Sign: | Date: | Contact Number:  |
| If information becomes superseded, indicate below and record updated information on new form |
|  |  |  |
| The information on this form has been superseded |
| Date: | Name: | Sign: |
|  |  |  |